Arbovirus Infection Case Investigation Form (Page 1of 2)

Communicable Disease Report
Important Instructions on Reverse Side - Please print or type
Send completed forms to your county or tribal health agency

County/IHS ID number:

Date Received by County:

State ID Number

Patient's name (Last) (First) (Middle Initial)

Date of birth

Sex
☐ Male
☐ Female

Race
☐ (1) White
☐ (2)Hispanic/Latino
☐ (3) Black
☐ (4)Asian/Pacific Isl.
☐ (5) Native American
☐ (8) Other
☐ (9) Unknown

Ethnicity
☐ Hispanic
☐ Non-Hispanic
☐ Unknown

Street address

Telephone no:

Mailing address (if different than above)

County or Tribal Residence

Pregnant
☐ Yes
☐ No

City or Town

State

Zip code

Census tract

Outcome
☐ Died
☐ Survived

Diagnosis or suspect reportable condition

Laboratory test

Specimen Type:

Date of onset

Date of diagnosis

Laboratory results

DateCollected:

DATE FINALED:

Patient's occupation or school

Local Health Agency use only

☐ Confirmed case
☐ Probable case
☐ Outbreak Associated
☐ Ruled out/ Non case

Physician or other reporting source Telephone no: Facility

Street address

City

State

Zip code

Communicable Disease Report to be completed at this time if not already filed.

ADHS/IDES-1(Rev.5-00)

Laboratory Results (Use Optional)

WBC	**Bacterial antigens**	**Other**
Viral culture	**Blood Culture**	
CSF Reports		
Protein	**Glucose**	**Gram Stain**
	% Lymphs	**CSF Culture**
CSF Viral Culture	**Herpes PCR**	**Other**

Transmit completed form to local health department

Private Lab Test **Name of Lab:** • **ARUP** • **Focus** • **LabCorp** • **Quest** • **Sonora Quest** • **Other:**	**Specimen Type:** • **Serum (acute)** **Coll. Date:**_____ • **Serum (convalescent)** **Coll. Date:**_____ • **CSF** **Coll. Date:**_____	**Test Type:** • **ELISA** • **Other:** **Test Done:** • **WNV** • **SLE** • **WEE** • **Other:**	**Virus Found:** • **WNV** • **SLE** • **WEE** • **Other:**
State Lab Test I **Lab No:**	**Specimen Type:** • **Serum (acute)** **Coll. Date:**_____ • **Serum (convalescent)** **Coll. Date:**_____ • **CSF** **Coll. Date:**_____	**Test Type:** • **ELISA** • **Other:** **Test Done:** • **WNV** • **SLE** • **WEE** • **Other:**	**Virus Found:** • **WNV** **P:N**_____ • **SLE** **P:N**_____ • **WEE** • **Other:**
State Lab Test II **Lab No:**	**Specimen Type:** • **Serum (acute)** **Coll. Date:**_____ • **Serum (convalescent)** **Coll. Date:**_____ • **CSF** **Coll. Date:**_____	**Test Type:** • **ELISA** • **Other:** **Test Done:** • **WNV** • **SLE** • **WEE** • **Other:**	**Virus Found:** • **WNV** **P:N**_____ • **SLE** **P:N**_____ • **WEE** • **Other:**

Arboviral Case Investigation Form (Page 2 of 2)

County/IHS ID number:

State ID Number

Patient's name (Last) (First) (Middle Initial)

Diagnosis at presentation:

- ☐ Uncomplicated Fever
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Asymptomatic
- ☐ Viremic Blood Donor
- ☐ Other:

Patient hospitalized?

- ☐ Yes, Admit date:
- ☐ No

Is patient breastfeeding a child?

- ☐ Yes
- ☐ No

Is patient a breastfed child?

- ☐ Yes
- ☐ No

Past medical history:

- ☐ Cancer
- ☐ Diabetes: type:
- ☐ Viral Hepatitis
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Immunosuppressive Condition
- ☐ Pulmonary Disease
- ☐ Mosquito-borne illness: Dengue, Yellow fever, Japanese encephalitis, WNV, SLE, flavivirus

Symptoms (Check all that apply – circle primary symptom):

- ☐ Headache
- ☐ Fever (> 38°C or 100°F)

Max. temp. :

- ☐ Neck pain/stiffness
- ☐ Arthralgia or Myalgia
- ☐ Photophobia
- ☐ Rash
- ☐ Seizure
- ☐ Lymphadenopathy
- ☐ Tremors
- ☐ Extreme fatigue
- ☐ Nausea/vomiting/diarrhea
- ☐ Shortness of breath
- ☐ Flaccid paralysis
- ☐ Spastic paralysis
- ☐ Profound muscle weakness
- ☐ Altered mental status
- ☐ Unconsciousness
- ☐ Other – *specify*:

Risk factor assessment:

Within 14 days of onset of symptoms, did the patient…

1) have known mosquito exposure? ☐ Yes ☐ No

Date: Location:

Date: Location:

2) travel outside county of residence? ☐ Yes ☐ No

Dates From: To:

Location:

Dates From: To:

Location:

3) travel outside Arizona? ☐ Yes ☐ No

Dates From: To:

Location:

Dates From: To:

Location:

4) travel outside US ? ☐ Yes ☐ No

Dates From: To:

Location:

Dates From: To:

Location:

5) donate blood? ☐ Yes ☐ No

Date:

6) donate an organ or tissue? ☐ Yes ☐ No

Date:

In the 30 days prior to onset of symptoms:

7) did the patient receive blood or blood product? ☐ Yes ☐ No

8) did the patient receive an organ or tissue transplant? ☐ Yes ☐ No

Vaccination history:

- ☐ Yellow fever Date:
- ☐ Japanese encephalitis Date:
- ☐ Tick-borne encephalitis Date:

Contact or person providing patient information, if other than patient:

Name: **Telephone:** **Relationship:**

Please FAX above information as soon as completed to :Maricopa County Dept of Health at 602 372-2630

Acquired:

- *in utero*? ☐ Yes ☐ No
- in a laboratory? ☐ Yes ☐ No
- occupationally (non lab)? ☐ Yes ☐ No

Length of Illness: days **Date of discharge , if hospitalized:**

Outcome:

- ☐ Died Date:
- ☐ Full Recovery
- ☐ Recovery with sequelae (describe):

Treatment (check all that apply):

- ☐ Immunoglobulin
- ☐ Interferon
- ☐ Other Antiviral
- ☐ Supportive care only
- ☐ None

Case Classification:

- ☐ Confirmed case
- ☐ Probable case
- ☐ Suspect
- ☐ Ruled out/ Non case

Case acquisition:

- ☐ Out of county
- ☐ Out of state
- ☐ Out of US
- ☐ Unknown

Investigator: **Date initiated** **Date completed:**